

Case Number:	CM15-0126018		
Date Assigned:	07/10/2015	Date of Injury:	10/04/1999
Decision Date:	08/11/2015	UR Denial Date:	06/10/2015
Priority:	Standard	Application Received:	06/30/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker (IW) is a 57-year-old male who sustained an industrial injury on 10/04/1999. Diagnoses include post laminectomy syndrome; lumbar disc disease; and lumbar radiculitis. Treatment to date has included medication, physical therapy (PT), acupuncture, a cortisone injection and TENS unit (with PT). According to the progress notes dated 5/14/15, the IW reported moderate to severe constant low back pain with right lower extremity radicular pain and numbness. The pain was rated 9/10. PT was helpful for the frequency of radicular symptoms and the TENS unit improved pain by 50% and lasted one to two days, allowing him to do home exercise. On examination, lumbar flexion was restricted to 50 degrees and lateral bending was restricted to 20 degrees bilaterally. Straight leg raise was positive at 30 degrees on the left side. Electrodiagnostic testing 9/19/06 found evidence of S1 radiculopathy. Lumbar spine MRIs from 2005 and 2009 showed degenerative changes and multilevel foraminal stenosis. A request was made for Terocin patches #30, Flurbi (nap) cream 180gms and Genicin 500mg, #90.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Flurbi (NAP) cream 180gms: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

Decision rationale: Regarding the request for this topical NSAID, the Chronic Pain Medical Treatment Guidelines state that topical NSAIDs are recommended for short-term use of 4-12 week duration for body regions that are amenable to topical treatment. Specifically, the CPMTG state: "There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder." A review of the submitted medical records indicates that the primary use of this topical flurbiprofen is for low back pain, an area specifically not recommended for use due to scant evidence. Given this, this request is not medically necessary.

Genicin 500mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine Page(s): 50.

Decision rationale: Genicin is a formulation of glucosamine. Regarding the request for Glucosamine the Chronic Pain Medical Treatment Guidelines state that glucosamine and chondroitin are recommended as an option in patients with moderate arthritis pain especially for knee osteoarthritis. Within the documentation available for review, there are no recent subjective complaints of moderate knee arthritis pain. Additionally, there are no radiographic or physical examination findings supporting a diagnosis of arthritis. As such, the currently requested Glucosamine (Genicin) is not medically necessary.

Terocin Patches QD #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Terocin Patch is a topical formulation consisting of Methyl Salicylate 25%, Capsaicin 0.025%, Menthol 10%, and Lidocaine 2.50%. The Chronic Pain Medical Treatment Guidelines, on pages 111-113, specify that, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Regarding the use of topical non-steroidal anti-inflammatory, guidelines state that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the 1st 2 weeks of treatment osteoarthritis, but either not afterwards, or with the diminishing effect over

another two-week period. Regarding use of capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to or are intolerant to other treatments. Regarding the use of topical lidocaine, guidelines state that it is recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Guidelines further stipulate that no preparation of topical lidocaine except as Lidoderm patch is approved. Therefore, since this component is not recommended, the entire Terocin formulation is not medically necessary.